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- A. Coordination of Benefits** Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. If the recipient is covered under other health insurance (including Medicare), Wisconsin Medicaid pays that portion of the allowable cost remaining after exhausting all other health insurance sources. Refer to Section IX of Part A, the all-provider handbook, for more detailed information on services requiring health insurance billing, exceptions, and the "Other Coverage Discrepancy Report."
- B. Medicare/Medicaid Dual Entitlement** Recipients covered under both Medicare and Wisconsin Medicaid are known as dual-entitlees. Claims for Medicare-covered services provided to dual-entitlees must be billed to Medicare *before* billing Wisconsin Medicaid.
- If the service for a recipient is covered by Medicare, but Medicare denies the claim, indicate a Medicare disclaimer code on the HCFA 1500 claim form. Although services covered by Medicare do not require prior authorization, providers are strongly encouraged to obtain prior authorization for dual-entitlees either at the time of initial Medicare claim submission or following a postpayment reconsideration. This ensures Medicaid payment if Medicare denies coverage.
- Therapy Crossovers Subject to Medicaid Payment Limitations**
Payments on certain therapy crossover claims from Medicare for dual-entitlees are subject to Medicaid maximum allowable fees and rates. Refer to Section IX of Part A, the all-provider handbook, for more information.
- C. QMB-Only Recipients** Qualified Medicare Beneficiary Only (QMB-only) and Qualified Medicare Beneficiary-Nursing Home (QMB-NH) recipients are only eligible for Medicaid payment of the coinsurance and the deductibles for Medicare-covered services. If services are denied by Medicare, they are *not* covered by Wisconsin Medicaid.
- D. Referring Provider** Claims for physical therapy services require the referring provider's name and UPIN number in elements 17 and 17a of the HCFA 1500 claim form. Refer to Appendix 1b of this handbook for billing instructions.
- E. Reimbursement Methodology** **Maximum Allowable Fees Based on Relative Value Units (RVUs)**
Medicaid maximum allowable fees for CPT-4 and HCPCS codes for physical therapy procedures are based on the national standard Medicare Relative Value Units (RVUs).
- The resource-based relative value scale (RBRVS) assigns RVUs based on the complexity of procedures. The RBRVS takes into account the provider's work for each procedure, practice expenses, and liability insurance. The work component includes the physical and mental intensity used to perform the service, the time taken to perform the service, and the pre- and post-face-to-face work associated with a typical encounter.
- The work RVUs for services are based on the expectation that the code's definition represents exactly how the service is furnished when billed to Wisconsin Medicaid.
- F. Payment Methods** **Conversion of Therapy Treatment Time to Medicaid Treatment Units for Billing Purposes**
For dates of service on and after September 1, 1995, the treatment unit of service is defined by the procedure code description. For example, when the description includes the statement 'each 15 minutes,' then one treatment unit of service is 15 minutes. If the description does not specify a time, the entire procedure, per date of service, equals one treatment unit of service. Part of a unit may be billed by using a number with a decimal point. Refer to Appendix 5 of this handbook for conversion charts. (Use the conversion charts applicable to the date of service.)

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**F. Payment Methods
(continued)**

Bill Face-to-Face Treatment Time Only

Bill the face-to-face treatment time actually provided. For example, if the procedure code description references 15 minutes of direct treatment, the provider must have furnished 15 minutes of direct, face-to-face treatment to the individual recipient to bill one unit of service.

Activities Included in a Treatment Unit

Based on CPT code definitions, only time spent in face-to-face treatment services to the individual recipient may be included in a Medicaid treatment unit.

Examples of face-to-face treatment time include the following:

- ✓ Time to obtain and update a history with the recipient present.
- ✓ Performing evaluation tests and measures with the recipient present.
- ✓ Face-to-face delivery of the physical therapy service to the recipient.

Non-face-to-face time is not included in a treatment unit. Examples of non-face-to-face treatment time include the following:

- ✓ Time to review records, score evaluation tests, and measures.
- ✓ Communication with other professionals, staff, and caregivers.

Non-face-to-face time is included in the reimbursement for the face-to-face service, as described under "Payment Methods."

**G. Daily Service
Limitations**

Ninety-Minute Daily Coverage Limitations

As specified in HSS 101.03 (96m) and HSS 107.02 (2) (b), Wis. Admin. Code, Wisconsin Medicaid does not cover physical therapy services beyond 90 minutes per day unless coverage of additional medically necessary treatment is requested and approved through the claims adjustment process (see the next paragraph). This limit is based on the determination that physical therapy services in excess of 90 minutes per day generally exceed the medically necessary, reasonable, and appropriate duration of physical therapy services.

If, under extraordinary circumstances, physical therapy treatment is necessary beyond the limitation of 90 minutes per day, coverage of additional treatment time may be requested by submitting an adjustment request form after the claim is paid. The specific medical reason for exceeding the 90-minute limitation must be documented on the adjustment request form. Refer to Section X and Appendices 27 and 27a of Part A, the all-provider handbook, for information on submitting an adjustment request.

Daily Unit of Service Limitation

Wisconsin Medicaid covers some procedure codes only a limited number of times a day. Refer to 'Daily Unit of Service Limit' in Appendix 4 of this handbook for specific limits.

H. Billed Amounts

Providers must bill their usual and customary charge for services provided. The usual and customary charge is the amount the provider charges for the same service when provided to a private-pay patient. For providers using a sliding fee scale for specific services, the usual and customary charge is the provider's charge for the service when provided to a private-pay patient. Providers may not discriminate against a Medicaid recipient by charging a higher fee for the service than is charged to a private-pay patient.

- H. Billed Amounts** Do not reduce the billed amount by the amount of recipient copayment. The applicable
(continued) copayment amount is automatically deducted from the Medicaid-allowed payment.

I. Claim Submission Paperless Claim Submission

As an alternative to submission of paper claims, the fiscal agent can process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as paper claims. Providers submitting electronically usually reduce their claim submission errors. Additional information on paperless claim submission is available by contacting the Electronic Media Claims (EMC) Department at:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

Paper Claim Submission

Submit procedure codes for physical therapy services on the HCFA 1500 claim form. A sample HCFA 1500 claim form and completion instructions are in Appendices 1, 1a, and 1b of this handbook.

Procedure codes for physical therapy services submitted on any other paper form than the HCFA 1500 claim form are denied.

The HCFA 1500 claim form is not provided by Wisconsin Medicaid or the fiscal agent. Claim forms are available from many suppliers, including:

State Medical Society Services
Post Office Box 1109
Madison, WI 53701
(608) 257-6781 (Madison area)
1-800-362-9080 (toll-free)

Mail completed claims submitted for payment to:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Submission of Claims

The fiscal agent must receive all claims for services rendered to eligible recipients within 365 days from the date of the service. This policy pertains to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals are in Section IX of Part A, the all-provider handbook.

- J. Diagnosis Codes** All diagnoses must be from *the International Classification of Diseases, 9th Edition, Clinical Modifications* (ICD-9-CM) coding structure.

Claims received without the appropriate ICD-9-CM code are denied.

Order the complete ICD-9-CM code book by writing to the address in Appendix 3 of Part A, the all-provider handbook.

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- J. Diagnosis Codes (continued)** Providers must note the following diagnosis code restrictions:
- ✓ Do not use codes with an "E" prefix as the primary or sole diagnosis on the HCFA 1500 claim form.
 - ✓ Codes with an "M" prefix are not acceptable on the HCFA 1500 claim form.
- K. Medicaid Procedure Codes** All HCFA 1500 claim forms require HCFA Common Procedure Coding System (HCPCS) codes. Claims or adjustments received without the appropriate codes are denied.
- Medicaid Physical Therapy Procedure Codes**
Refer to Appendix 4 of this handbook for Medicaid HCPCS procedure codes for billing and prior authorization for dates of service on and after September 1, 1995. Wisconsin Medicaid will notify providers when Wisconsin Medicaid adopts changes to these procedure codes.
- Refer to Appendix 4 of this handbook for procedure codes for billing physical therapy services for dates of service before September 1, 1995.
- Billing Evaluation Services in Facilities for the Developmentally Disabled**
Effective September 1, 1995, evaluation services in facilities for the developmentally disabled (FDD) use HCPCS comprehensive evaluation procedure codes. Refer to Appendix 4 of this handbook for HCPCS procedure codes.
- L. Modifiers**
- How to Bill Using Modifiers**
PTs, rehabilitation agencies, and therapy groups must add modifiers when billing for *all* physical therapy services.
- Modifiers allow PTs and Wisconsin Medicaid to distinguish between physical and occupational therapy services with identical procedure codes. The modifier for physical therapy procedure codes is "PT."
- Paper Claims Submission**
Enter the "PT" modifier in element 24d on the HCFA 1500 claim form or the claim will deny.
- Paperless Claim Submission**
Enter the "PT" modifier immediately after the procedure code in field "M1," or the claim will deny.
- For example, a PT bills procedure code 97119 (therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility). The PT enters the "PT" modifier in element 24d on the HCFA 1500 claim form.
- M. Follow-up to Claim Submission** To ensure that your claim is not denied, complete the claim form using:
- ✓ The *same* prior authorization number that is on the PA/RF.
 - ✓ The *same* modifier for the same procedure code that is on the PA/RF.

**M. Follow-up to Claim
Submission**
(continued)

Providers are responsible for initiating follow-up procedures on claims submitted to the fiscal agent. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Refer to Appendix 17, for a list of EOB codes (denial codes), how to avoid claim denials, and a sample Remittance and Status Report with EOB codes. The fiscal agent takes no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to the fiscal agent. Section X of Part A, the all-provider handbook, includes detailed information regarding the following:

- ✓ The Remittance and Status Report.
- ✓ Adjustments to paid claims.
- ✓ Return of overpayments.
- ✓ Duplicate payments.
- ✓ Denied claims.
- ✓ Good Faith claims filing procedures.

Refer to Appendix 14 of this handbook for helpful hints for working with Wisconsin Medicaid.